| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 09G098 | GOVERNMENT OF THE DISTRICT OF COLUMBIA HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 | 11/04/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MULTI-THERAPEUTIC SERVICES, INC | 927 55TH STREET, NE WASHINGTON, DC 20019 |

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| W 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted from November 2, 2009 through November 4, 2009. The fundamental survey process was utilized. A random sampling of three clients was selected from a residential population of five females with mental retardation and other disabilities.<br><br>The survey findings were based on observations and interviews in the group home and at two day programs, and a review of records, including unusual incident reports. | W 000 | | |
| W 104 | 483.410(a)(1) GOVERNING BODY<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to implement an effective system to ensure agreements between the day program provider and the group home was executed for two of three clients in the sample. (Clients #1 and #2)<br><br>The finding includes:<br><br>On November 12, 2009 at approximately 8:55 A.M. Client #1 was observed leaving the facility with her peers and direct care staff. At 2:10 p.m., the client was observed leaving the facility with staff to bring her peers home from the day program.<br><br>Interview with the direct care staff revealed that there was a problem with Client #1's day program and that she had not attended since the summer. | W 104 | 55th Survey Responses 12 09<br><br>W104<br><br>MTS does have systems and dedicated staff to insure that day program "Pass Through" payments are disseminated to its sister day providers in a timely manner but MTS nor any other residential provider can unilaterally address pass through payment concerns when they are based on processing issues at ACS or Health Care Finance. It should be noted that MTS has not had similar problems with its other sister day providers, only this particular one.<br><br>Even though the payment problem experienced by the day provider did not accrue to MTS' failure to properly process payments or disseminate payments received in a timely manner, this day provider decided to suspend the individuals involved thereby denying them active treatment services they need. That act amounts to punishing the person supported for a payment concern that is beyond their control and that of MTS. In such cases, MTS will advocate for the right of the person to choose another day provider who can meet their needs. MTS is currently moving in that direction for Client #1 and #2 supported by DDS... 12-30-09.<br><br>As it has in the past, MTS will insure in the future:<br><br>• Day service billings received will be processed in a timely manner by the MTS accounting staff member dedicated to that task;<br>• System checks will be completed to track the processing of the billings;<br>• Day programs will be notified when payments and remittance information is received;<br>• Payments will be provided to the day program within 48 hours of receiving the check and remittance advice;<br>• MTS will work with its sister day providers to resolve any pass through payment concerns that develop... 12-30-09. | |

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Evette Moore (Freda G. Edwards) | TITLE: Director of Residential Services | (X6) DATE: 12/14/09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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| W 104 | Continued From page 1<br>During an interview with the Qualified Mental Retardation Professional (QMRP) on November 2, 2009 at 9:25 a.m., it was revealed that on July 13, 2009 Clients #1 and #2 were suspended from their day program for nonpayment for services. The QMRP indicated that she and the clients' case manager attended a meeting at the day program to discuss the issue on August 12, 2009. According to the QMRP, during the meeting the group home alleged that payments were current.<br><br>Interview with the QMRP and the day program case manager revealed that Client #2 was readmitted to her day program on September 17, 2009. At the time of the survey, however, the QMRP indicated that the group home provider had been unsuccessful in resolving Client #1's financial issue with the day program.<br><br>Interview with the case manager on November 2, 2009 at 11:32 AM revealed the day program confirmed that Client #2 returned to the program on September 17, 2009. Further interview with the case manager indicated that Client #1 had not been permitted to return to the day program because of non-payment for services rendered.<br><br>A telephone interview on November 4, 2009 at 2:45 P.M. with the agency's chief financial officer revealed that it was the policy of the provider to review the service invoices submitted by the day treatment providers for accuracy upon receipt. After verification of the invoices, the provider should sign them and forward them to the funding agency for processing and payment. The funding agency provides written remittance advice, and if there are no concerns, issues a check to the group home provider to be passed on to the day treatment provider. The chief financial officer | W 104 | | |

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| W 104 | Continued From page 2<br>acknowledged that the agency had experienced intermittent delays in receiving day program payments from the funding agency, which in the past had prevented the agency from sending payments to the day program within timeframe required by the agreement. The chief financial officer, however, indicated that Client #1's day program debt might be partially related to an inadvertent day program book keeping error.<br><br>The review of the Agreement for the Provision of Active Treatment Services to Residents of Intermediate Care Facilities for Person with Mental Retardation revealed the following information:<br><br>"If MAA's fiscal intermediary denies any claims submitted by ICF/MR for services provided by Active Treatment Provider for any billing cycle, ICF/MR agrees to provide a copy of the remittance advice to Active Treatment Provider as soon as possible so that Active Treatment Provider is aware of such denials and the reasons for them."<br><br>Although interview with the QMRP and the residential program director revealed that new day placements was being sought for both Client #1 and #2, there was no evidence that an effective system had been implemented to prevent the alleged untimely payment for day treatment services, which had resulted in the clients' suspension from their day programs. | W 104 | | |
| W 153 | 483.420(d)(2) STAFF TREATMENT OF CLIENTS<br><br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported | W 153 | | |

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| W 153 | Continued From page 3<br>immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview, and record review, the facility failed to ensure an incident of a missed medication at the day program was reported to DOH as required by local law for one of the three clients in the sample. [Client #3]<br><br>The finding includes:<br><br>Record review on 11/3/2009 at approximately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Client #3's habilitation record. The incident report was dated 2/11/2009 from Client #3's day program and it provided information regarding an "omission of medications." A memorandum from the day program was attached to this incident report and it detailed the following:<br><br>"On 2/11/2009, eighteen individuals at [Day Program] missed their 12noon dosage of prescribed medications/or treatments. The temporary registered nurse assigned by [Staffing Agency] to administer medication on this date failed to complete this responsibility."<br><br>Further record review revealed on the same day at approximately 10:40 a.m. revealed, Client #3 was prescribed to receive 10mg of Reglan (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders.<br><br>Interview with the qualified mental retardation | W 153 | W153<br><br>This is a case of an incident occurring at the day program that was not detected or reported in a timely manner. Once the day program did uncover the issue, it disclosed to MTS and provided its investigation report. MTS could not report what it did not know about and perhaps incorrectly assumed that the day program would disclose the incident to the State Agency as well as provide its investigation report. In the future, MTS will insure that it forwards any incident reports and investigations it receives from day programs for incidents that occur at the day program to the State Agency the same day that it receives it...12-20-09.<br>It should be noted that no harm resulted in the missed medication passes and that this was a single occurrence caused by the circumstances that day at the program and not an ongoing concern or problem. Nevertheless, the QMRP will monitor this consideration during her routine, monthly visits to the program...12-20-09. | |

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| W 153 | Continued From page 4<br>professional (QMRP) on 11/3/2009 at approximately 2:07 p.m. revealed she was notified of the missed medication on 3/9/2009. She was not sure why it took the day program almost a month to notify her of the incident. The QMRP however failed to notify the Department of Health of this medication error as well. | W 153 | | |
| W 156 | 483.420(d)(4) STAFF TREATMENT OF CLIENTS<br><br>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview and record review the facility failed to ensure an investigation into an incident of a missed medication at the day program as required by this section for one of three clients in the sample. [Client #3]<br><br>The finding includes:<br><br>Record review on 11/3/2009 at approximately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Client #3's habilitation record. The incident report was dated 2/11/2009 from Client #3's day program and it provided information regarding an "omission of medications." A memorandum from the day program was attached to this incident report and it detailed the following:<br><br>"On 2/11/2009, eighteen individuals at [Day Program] missed their 12noon dosage of prescribed medications/or treatments. The temporary registered nurse assigned by [Staffing | W 156 | W156<br><br>See the responses for W153. In addition, the QMRP did not seek to conduct an investigation at the day program based on the described incident. The day program conducted its own investigation and provided MTS with its report/findings. Residential staff cannot conduct investigations at non-affiliated, sister day programs unless given special permission to do so or the program agrees to a joint investigation. Neither was necessary in this case. The day program, once it uncovered the incident, investigated and provided its findings. As mentioned in W153, MTS will insure that it passes on such incident reports and investigations received from day programs the day they are received... 12-20-09. | |

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| W 156 | Continued From page 5<br>Agency] to administer medication on this date failed to complete this responsibility."<br><br>Further record review revealed on the same day at approximately 10:40 a.m. revealed, Client #3 was prescribed to receive 10mg of Reglan (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders.<br><br>Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:08 p.m. revealed she did not complete an investigation into this incident. As such, the QMRP also failed to provide the Department of Health with her investigative findings as well. | W 156 | | |
| W 159 | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for three the three clients in the sample. (Clients #1, #2 and #3)<br><br>The findings include:<br><br>1. The facility's QMRP failed to ensure the coordination of outside services. [See W120]<br><br>2. The facility's QMRP failed to ensure that each | W 159 | W159<br><br>MTS has addressed the issues cited under W159 as evidenced by the responses provided for W120, W189, W217, W249, W263 and W264. | |

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| W 159 | Continued From page 6<br>employee had been provided with adequate training that enables the employee to perform his or her duties effectively. [See W189]<br><br>3. The QMRP failed to ensure coordination between the interdisciplinary team, to include the primary care physician (PCP) in the final decision-making process for determining the most appropriate food consistency for Client #2. [See W217]<br><br>4. The facility's QMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations. [See W249]<br><br>5. The facility's QMRP failed to ensure the coordination of services to ensure client's received their medications under informed consent. [See W263]<br><br>6. The facility's QMRP failed to ensure restrictive measures were implemented only with the written informed consent of the Human Rights Committee. [See W264] | W 159 | | |
| W 217 | 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN<br><br>The comprehensive functional assessment must include nutritional status.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that the comprehensive functional assessment included a thorough evaluation of clients' eating skills to determine the appropriateness of dietary recommendations, for one of three clients in the sample. (Client 2). | W 217 | | |

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| W 217 | Continued From page 7<br><br>The finding includes:<br><br>On 11/2/09 at 1:00 p.m., Client #2 was observed independently eating a meal of pureed foods and regular consistency liquids at her day program. She rapidly ate the food requiring intermittently verbal prompting from the staff her to reduce her eating pace. Interview with day program staff during this time confirmed that the client was able to feed herself, however, required verbal prompting to prevent her from eating her prescribed pureed diet too rapidly.<br><br>On 11/ 2/09 at 4:25 p.m., at her group home, the client fed herself a snack of pudding from a cup. At approximately 6:50 p.m. on the same day, the client fed herself. Facility staff verbally prompted Client #2 to eat more slowly during the meal.<br><br>Interview with group home staff on 11/309 at approximately 3:15 p.m. revealed they were aware of the Speech/Language Pathologist's (SLPs) assessment, which indicated that the client was able to tolerate bite-size pieces of soft bread-type desserts. Staff also reported that the nutritionist had approved the client to have "have soft items i.e. cakes, honey buns, soft cookies, and brownies for snack (It is to be given in bite size).<br><br>The review of quarterly nutritional assessments dated 6/ 30/09 and 9/5/09 on 11/ 3/09 at 1:27 p.m., confirmed the staff statements that the client may have soft cakes like honey buns and brownies. Further record review on 11/3/09 at 3:15 p.m. revealed a SLP Assessment dated 7/808, which stated "Swallow function: Tolerates current diet (pureed). Should continue to monitor | W 217 | | |

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| W 217 | Continued From page 8<br>for pacing during meals." The SLP assessment stated the client should have pureed texture foods, however "can have soft items i.e. cakes, honey buns, soft cookies, and brownies for snack (It is to be given in bite size)."<br><br>Review of Client #2's Mealtime Protocol dated November 2008 revealed Pureed Regular Diet. "Can have soft items i.e. cakes, honey buns, soft cookies, and brownies for snack (It is to be given in bite size). The review of the physician's orders dated 10/01/09, however, revealed a "Pureed - Regular- Low Cholesterol Diet" was prescribed for the client. The was no evidence that the nutritionist and/or the SLP had sought the approval of the PCP prior to recommending Client #2 to have bite size soft bread type desserts prior to their being documented in the professional assessments and recommendations. | W 217 | W217<br><br>MTS will have another swallowing study done for Client #2 to be sure that some texture other than pureed can be given. MTS will insure that the specialist is aware of the existing Speech Pathology recommendation that indicates soft, bite-sized foods can be provided. Once the results of the new swallowing study are in hand, they will be shared with the PCP, Speech Pathologist and Nutritionist. The team will decide whether to modify the diet orders at that point, and if they do, the physician's orders will be changed to reflect the team's decision...12-30-09. | |
| W 249 | 483.440(d)(1) PROGRAM IMPLEMENTATION<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to ensure that clients receive interventions as specified in their ISP for one of three sampled clients. (Client #3)<br><br>The finding includes: | W 249 | W249<br><br>Client #3 completed a number of her measurable objectives during the course of the ISP year and reached her maximum potential on others. On 12-16-09, an ISP team meeting will be held and new objectives will be approved. The new objectives will be implemented by...12-19-09.<br>In the future, the QMRP will insure that completed or "Maxed out" objectives are replaced with new objectives by completing addendums to the ISP with the team's approval...12-20-09.<br>The Daily Activity Schedules for each individual supported will be revised to reflect both their measurable objectives (implementation schedule) and supported routines that are conducted routinely (i.e. individuals supporting completing all daily living tasks as supported by staff). The QMRP will train staff on involving the individuals supported in all daily living tasks, regardless of their skill levels...12-30-09.<br>Additionally, the QMRP and Facility Manager will observe active treatment implementation at minimum twice weekly (apiece) to insure that measurable objectives and supported routines are consistently implemented...12-30-09. | |

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| W 249 | Continued From page 9<br><br>On 11/2/2009 between the hours of 3:30 p.m. and 6:50 p.m., Client #3 was observed sitting in front of a small table in the living room listening to music from a small portable radio. Client #3 was escorted from this seat between 5:52 p.m. and 6:21 p.m. to have dinner. After dinner she was allowed to return to her chair to listen to more music. She remained there until 6:50 p.m. when the survey team left the facility.<br><br>1. Record review on 11/3/3009 at approximately 10:55 a.m. revealed, Client #3's Individualized Service Plan (ISP) dated 12/16/2008 outlined four new habilitation programs were recommended for this year. The programming objectives were listed as follows:<br><br>a. To enhance ADL skills: "Given physical prompts [Client #3] will put her soiled clothes in the hamper on 10/10 sessions. (NEW GOAL)"<br>b. To enhance gross motor skills: "[Client #3] will roll the ball on 8/8 sessions given visual cues. (NEW GOAL)"<br>c. To increase social and adaptive behaviors: "[Client #3] will reduce episodes of aggressive behaviors to 0 per month for 9 months."<br>d. To increase self-help skills: "[Client 33] will hang coat up given physical prompts on 8/8/ sessions. (NEW GOAL)"<br><br>Further record review on the same day at approximately 11:05 a.m. revealed Client #3's Psychology assessment dated 12/5/2008 recommended take part in "active engagement daily especially during the hours between 4-6 pm" as a proactive means of preventing Client #3's targeted behaviors. | W 249 | | |

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| W 249 | Continued From page 10<br>Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:20 p.m. revealed none of the above "new goals" were being implemented.<br><br>The facility failed to ensure the timely implementation of Client #3's habilitation as recommended by the Interdisciplinary Team (IDT).<br><br>2. Record review on 11/3/3009 at approximately 11:05 a.m. revealed, Client #3's Speech (SLP) assessment dated 7/7/2008 recommended the following:<br><br>a. Continue building [the] Client's receptive and expressive language skills through recreational/social interactions as well as using 1 to 1 time allowing client to express herself.<br><br>b. Re-assess communication skills annually to monitor significant changes and adjust programming as necessary.<br><br>Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at 2:50 p.m. revealed Client #3 did not have a current communication program in place and an updated SLP assessment was still pending.<br><br>The facility failed to ensure the timely implementation of Client #3's communication program and re-assessment as recommended by the Speech and Language Pathologist (SLP). | W 249 | | |
| W 261 | 483.440(f)(3) PROGRAM MONITORING & CHANGE<br><br>The facility must designate and use a specially constituted committee or committees consisting | W 261 | | |

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| W 261 | Continued From page 11<br>of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on this committee for two of three clients included in the sample. (Clients #1 and #2)<br><br>The finding includes:<br><br>On 11/ 3/09, at 10:20 a.m., interview with the Qualified Mental Retardation Professional revealed that the facility's specially constituted committee had reviewed the restrictive measures (behavior intervention techniques and/or medications) for Clients #1 and #2 at a meeting on 12/19/08. On 11/4/09 at 3:06 pmM., review of the HRC minutes dated 12/08 for the meeting during which the clients behavior support plan were discussed revealed no signatures (s) of individuals with no controlling interest in the facility. Interview with the QMRP revealed that all attendees on that day were employed by the agency. Further interview with the QMRP revealed that no individuals without controlling interest in the facility had attended meeting. | W 261 | W261<br><br>The Executive Director of the program will insure that the MTS non-affiliated members of the Human Rights Committee attend/participate in all meetings as evidenced by the signature sheets and minutes... 12-30-09. | |
| W 263 | 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE<br><br>The committee should insure that these programs | W 263 | W263<br><br>The guardian of Client #3 was provided with a risks/benefits discussion of the psychotropic drug regimen before agreeing to approve it by signing the consent form. The consent form will be modified to list the potential side effects of the medication(s) and the medication itself and the guardian will be asked to sign the modified form... 12-30-09.<br>This modified form will be used universally thereafter... 12-30-09. | |

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| W 263 | Continued From page 12<br>are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure clients psychotropic medication regimen was implemented with the informed consent of a client ' s guardian for one of three clients in the sample. [Client #3]<br><br>The finding includes:<br><br>Observation on the morning of 11/2/2009 revealed Client #3 was administered a regimen of psychotropic medications, which included 300mg of Tegretol for compulsive behavior. A review of the 10/2009 physician's orders the following day at approximately 11:35 p.m. revealed this client was also prescribed 75mg of Anafranil (Clomipramine HCL) every evening for compulsive behavior.<br><br>Further record review revealed a "Consent for Treatment with Psychotropic Medication" form was signed by Client #3's medical guardian on 3/18/2009. The consent form did not list the medications Client #3 was receiving nor did it list the "common side effects" of those medications as well. In addition, the medical guardian did not indicate if she "consented" or "did not consent" for the use of the psychotropic medications due to the check boxes being left blank on the consent form.<br><br>There was no evidence on file to substantiate the Medical Guardian provided proper information on or truly provided written consent for Client #3's | W 263 | | |

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| W 264 | Continued From page 14<br>revealed there was no evidence the door alarms were reviewed and or assessed dating back to 1/2009 of this year. It was not clear why the alarms were still active despite not having any approval from the HRC to continue implementing them. | W 264 | | |
| W 322 | 483.460(a)(3) PHYSICIAN SERVICES<br><br>The facility must provide or obtain preventive and general medical care.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure preventive health services were coordinated for the completion of recommended diagnostic procedures for two of three clients in the sample. (Clients #1 and #2)<br><br>The finding includes:<br><br>1. The facility failed to ensure that Client #2 received a hematology follow-up as prescribed.<br><br>On 11/ 2/09 at 8:02 a.m., Client #2 was observed to receive Ferrous Sulfate 325 (65 mg) tablet. Interview with the medication nurse during this time revealed the client received the medication to prevent a low iron level. Record verification on 11/ 3/09 at 9:05 a.m. confirmed that the client had a physician's order to receive Ferrous Sulfate 325 (65 mg) tab TID on Monday through Friday and BID on Saturday and Sundays for anemia.<br><br>Interview with the primary R.N. on 11/3/09 at 11:00 a.m. revealed the hematologist was monitoring Client #2. Record review revealed a | W 322 | W322<br><br>Client #2 received hemarology follow up on...11-6-09 (Copy attached)<br>Client #1 had a Prolactin level done on 9-26-09 (copy attached)...9-26-09.<br><br>The level was high and the PCP will monitor the level but indicated that the current level is not an issue unless she begins lactating...12-14-09.<br><br>The new RN will insure that all medical follow up occurs in a timely manner by using MTS standard forms to track all needed follow up in a person-specific manner...12-30-09.<br>In addition, the RN, QMRP and Facility Manager meet monthly to review medical follow up concerns and to assure all are addressed...12-20-09.<br>Finally, the LPN support office will assist the RN in assuring that medical consultations are tracked, scheduled and implemented in a timely manner...12-30-09. | |

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| W 322 | Continued From page 15<br>hematology consultation report dated 6/23/08 in which it was noted the client had a diagnosis of microcytosis and should return to the hematology clinic in one year for follow-up. At the time of the survey, there was no evidence that the one year follow-up appointment had been completed for the client.<br><br>2. The facility failed to ensure the pharmacist's recommendation that Client #1's Prolactin be monitored every six months was addressed as evidenced below:<br><br>On 11/ 2/09 at 8:30 a.m., Client #1 was observed being administered Haldol 5 mg tab (3 tabs, 15 mg). The client laid on the floor and attempted to bang her head as the nurse verbally prompted her to get up from the floor. Interview with the medication nurse revealed the Haldol was prescribed to manage the client's psychosis. Subsequent record review on 11/2/09 at 9:07 a.m. revealed a current physician's order, with an original date of 7/7/08 for Haloperidol 5 mg tab, 15 mg by mouth twice daily in the morning and evening for psychosis.<br><br>Record review on 11/ 4/09 at 9:17 a.m. revealed a 5/11/09 Quarterly Pharmacy Review which stated "Haldol - Needs Prolactin Q 6 months." The review of the client's Quarterly Pharmacy Reviews dated 11/ 25/08, 2/25/09, and 8/6/09 revealed assessment of the Client ' s prolactin level was also recommended at those times. Continued record review however revealed no laboratory reports of prolactin level were available.<br><br>Interview with the primary R.N. on 11/ 4/09 at 9:30 a.m. revealed that no laboratory tests had | W 322 | | |

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| W 322 | Continued From page 16 | W 322 | | |
| | been conducted to assess Prolactin values. | | | |
| W 331 | 483.460(c) NURSING SERVICES | W 331 | | |
| | The facility must provide clients with nursing services in accordance with their needs. | | | |
| | This STANDARD is not met as evidenced by: Based on observation, interview, and record verification, the facility's nursing services failed to ensure each resident received laboratory assessments as recommended and prescribed for two of the three clients in the sample. (Clients # 1 and #2) | | | |
| | The findings include: | | | |
| | 1. On 11/2/09 at 8:02 a.m., Client #2 was administered Ferrous Sulfate 325 (65 mg) tablet. Interview with the medication nurse during this time revealed the client received the medication to prevent a low iron level. | | | |
| | Record verification on 11/2/09 at 9:05 a.m. confirmed that the client had a physician's order for Ferrous Sulfate 325 (65 mg) tab TID on Monday through Friday and BID on Saturday and Sundays for anemia. | | | |
| | Record review on 11/3/09 revealed a physician's ordered dated 5/11/09 prescribing CBC lab test every three months lipid test every six months to monitor the client. Further review of the client's medical record on 11/3/09 at 11:35 AM, revealed the following laboratory results: | | | |
| | CBC: 12/22/08 (12.2 gm.) and 11/26/09 (13.1 gm.) | | | |

W331

The cited lab work for Clients #2 will be scheduled by...12-20-09.
Results will be forwarded to the RN and PCP immediately.
In the future, the RN will use the prescribed, person-specific tracking formats to insure that all lab work is completed as prescribed by the PCP and ISP...12-30-09.
In addition, the QMRP will audit the medical records monthly to support the RN...12-30-09.

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| W 331 | Continued From page 17<br>During a follow-up interview on 11/4/09 at 1:11 p.m., the primary R.N. acknowledged that no additional CBC values were available. There was no evidence the facility had ensured that the client's laboratory assessments had been conducted at the frequency prescribed by the primary care physician.<br><br>2. On 11/2/09, at 4:24 p.m. Client #2 was observed eating a snack of pudding. Interview with the staff indicated the client was prescribed a low cholesterol pureed diet.<br><br>On 11/3/09 at 9:17 a.m., the review of physician ' s orders dated 10/1/09 for Client #2 revealed she was prescribed a Pureed-Regular-Low cholesterol diet. Further record review revealed a physician's ordered dated 5/11/09 prescribing that a lipid panel be conducted every six months. Available lipid panel results in the client's record were dated 12/22/08 and 3/10/09.<br><br>During a follow-up interview on 11/4/09 at 1:11 p.m., the primary R.N. acknowledged that no additional lipid report values were available for the client. There was no evidence the facility had ensure that the client's lipid panels were conducted at the frequency prescribed by the primary care physician.<br><br>3. [Cross refer to W322.2] The facility's nursing services failed to coordinate the pharmacist's recommendation for monitoring of Client #1's serum prolactin level with the primary care physician. | W 331 | | |
| W 336 | 483.460(c)(3)(iii) NURSING SERVICES<br><br>Nursing services must include, for those clients certified as not needing a medical care plan, a | W 336 | | |

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| W 336 | Continued From page 18<br>review of their health status which must be on a quarterly or more frequent basis depending on client need.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that each client received a physical examination by a Registered Nurse at least quarterly, for two of the three clients in the sample. (Clients #1 and #2)<br><br>The findings include:<br><br>Interview with the primary R.N. on 11/3/09 at 4:40 p.m. revealed that she began working at the group home on 8/13/09. Further interview with the R.N. revealed at that time she began a review of all client's records to determine the status of assessments and appointments/consultations.<br><br>On 11/4/09 at 9:22 a.m., and 11:29 a.m. respectively, review of medical records of Clients #2 and #1 revealed that a six-month period had elapsed between quarterly nursing assessments as follows;<br><br>a. Client #2 had a 2nd quarterly assessment on 4/3/09, then the next nursing quarterly was conducted on 10/7/09, 5 months later.<br><br>b. Client #1 had a 2nd quarterly assessment on 4/9/09, then next nursing quarterly assessment was conducted on 9/28/09, 5 months later.<br><br>The R.N. acknowledged that there had been a break between the time the previous primary R.N. was transferred from the facility and the time that she began working at the facility. There was no | W 336 | W336<br><br>As indicated by the surveyor, a gap in completing quarterly nursing physicals was created by the departure of one RN and the time it took to replace her. Quarterly nursing physicals are current for each person supported at this time. In the future, the Director of Nursing will insure that no such gap occurs by assigning another RN to complete the task, using consultants in the absence of a permanent RN or by completing the task herself...12-30-09. | |

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| W 336 | Continued From page 19<br>evidence that the facility had ensure that each client received a physical assessment at least quarterly. | W 336 | | |
| W 350 | 483.460(e)(3) DENTAL SERVICES<br><br>The facility must provide education and training in the maintenance of oral health.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure effective education and training in the maintenance of good dental hygiene for two of the three clients in the sample. (Clients #1 and #2)<br><br>The findings include:<br><br>1. The facility failed to ensure training to staff and the clients as recommended to improve the clients' dental hygiene.<br><br>Interview with the staff on 11/2/09 at 3:37 p.m. revealed the clients required assistance in all activities of daily living, including tooth brushing. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the clients did not have formal training objectives to enhance their skills in toothbrushing. Further interview with the QMRP, however, revealed that staff had been instructed to assist the client's in brushing their teeth three times daily and to document the toothbrushing in the clients' record.<br><br>Record review 11/4/09 at 4:00 p.m. verified that the QMRP had instructed the staff during a meeting on January 9, 2009, to brush the clients' teeth 3 times daily, however, all staff had not been present at the meeting. Subsequently, there | W 350 | W350<br><br>All staff will receive oral hygiene training from the RN with emphasis put on supporting individuals with proper tooth brushing...12-30-09.<br>It should be noted that Client #1 presents specific issues around oral hygiene and dental care because she resists staff support and the dentist when she receives treatments. The dentist is successful in treating her despite the behavior and staff incurs similar issues when supporting her during tooth brushing. The QMRP will consult with the behavior specialist to determine if a protocol can be developed that will help staff be more successful in supporting Client #1 during tooth brushing. If it is determined that a protocol can help, the behavior specialist will develop it and train staff on the prescribed techniques...12-30-09. | |

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| W 350 | Continued From page 20<br>was no evidence that each staff had been trained on dental hygiene.<br><br>Further interview with the primary R.N. on 11/3/09 at 12:15 p.m., revealed that the dental visits for Clients #1 and #2 were current.<br><br>2. The review of dental consultation reports for Client #1 and #2 revealed poor oral hygiene had been identified during dental assessments as evidenced below:<br><br>a. On 11/4/09 at 9:39 a.m., Client #1 dental consultation report dated 11/26/08 revealed a large amount of plaque and calculus, and that material alba was present on tooth surfaces. The client received a general scaling with prophylaxis and polishing on 1/27/09. Brushing two to three times daily was recommended. On 5/18/09, the client was again diagnosed with large deposits of plaque and calculus. She was recommended to return to the dental clinic for a full mouth scaling, which she received on July 28, 2009. There was no evidence, however, that the toothbrushing procedures implemented had been adequate to prevent the rapid accumulation of plaque and calculus on the client's teeth.<br><br>b. Record review on 11/4/09 at 12:12 p.m., revealed that Client #2 had a dental consultation on 11/26/08. The finding was "large amount plaque, calculus, and material alba present on teeth surfaces. Poor oral hygiene." On 1/27/09, the client returned to the dentist for generalized scaling prophylaxis and polishing of teeth. Brushing two to three times daily was recommended. During a follow-up appointment on 5/18/09, the client was again diagnosed with moderate deposits of plaque and calculus. At the | W 350 | | |

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| W 350 | Continued From page 21<br>time of the survey, there was no evidence evidence that the facility had implemented an effective brushing program to improve the client's dental hygiene. | W 350 | | |
| W 368 | 483.460(k)(1) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that medication was administered without error for one of three clients in the sample. (Client #2)<br><br>The finding includes:<br><br>Interview with the primary R.N. on 11/3/09 at 2:18 p.m. revealed that Client #2's treatment prescribed to prevent ear wax impaction was changed by the primary care physician in July 2009.<br><br>Record review on 11/3/09 at 4:49 p.m. revealed a physician's order dated 7/21/09 for H2O2 (Hydrogen Peroxide) + Mineral Oil 1/2/ + 1/2 in dropper bottle, 3 gtt to each ear 3 x a month - each ear. The review of the medication administration record, however, revealed no documentation that the peroxide (H2O2) + mineral oil drops had not been administered to the client on any day in July 2009. There was no evidence the facility ensured the client's medication was administered without error. | W 368 | W368<br><br>Interviews with medication nurses indicate that the treatment was given but not properly documented (Hydrogen Peroxide to ears). The RN will train medication passing nursing to insure that they document all medications and treatments consistently...12-30-09. Additionally, the RN will audit the MARs at minimum weekly to insure the above...12-30-09. | |

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| I 000 | INITIAL COMMENTS<br><br>A re-licensure survey was conducted from November 2, 2009 through November 4, 2009. A random sampling of three residents was selected from a residential population of five females with mental retardation and other disabilities.<br><br>The survey findings were based on observations and interviews in the group home and at two day programs, and a review of records, including unusual incident reports. | I 000 | | |
| I 183 | 3508.4 ADMINISTRATIVE SUPPORT<br><br>Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff interview, and record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services, for three the three residents in the sample. (Residents #1, #2 and #3)<br><br>The findings include:<br><br>1. The GHMRP's QMRP failed to ensure the coordination of outside services. [See Federal Deficiency Report Citation W120]<br><br>2. The GHMRP's QMRP failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively. [See Federal Deficiency Report Citation W189] | I 183 | Chapter 35<br><br>3508.4<br><br>MTS has addressed the issues cited under W159 as evidenced by the responses provided for W120, W189, W217, W249, W263 and W264 | |

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| I 183 | Continued From page 1<br>3. The QMRP failed to ensure coordination between the interdisciplinary team, to include the primary care physician (PCP) in the final decision-making process for determining the most appropriate food consistency for Resident #2. [See Federal Deficiency Report Citation W217]<br><br>4. The GHMRP's QMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations. [See Federal Deficiency Report Citation W249]<br><br>5. The GHMRP's QMRP failed to ensure the coordination of services to ensure resident's received their medications under informed consent. [See Federal Deficiency Report Citation W263]<br><br>6. The GHMRP's QMRP failed to ensure restrictive measures were implemented only with the written informed consent of the Human Rights Committee. [See Federal Deficiency Report Citation W264] | I 183 | | |
| I 224 | 3510.5(a) STAFF TRAINING<br><br>Each training program shall include, but not be limited to, the following:<br><br>(a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills;<br><br>This Statute is not met as evidenced by:<br>Based on record review, the Group Home for the | I 224 | 3510.5(a)<br><br>Staff receives overview of MR training during orientation. The QMRP will schedule training sessions for staff to address this training area and all others cited in other 35 tags in this survey. The trainings will be scheduled by...12-20-09.<br>And will be completed by 12-30-09.<br>Additionally, the QMRP will develop a first half of 2010 staff training schedule that covers all required trainings and will repeat that activity for the second half of the year...1-15-10.<br>MTS in also reorganizing both its initial orientation training and its annual training calendars to reflect the new DDS mandates and will implement a 2010 schedule that reflects the DDS mandates in 2010...1-30-10. | |

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| W 263 | Continued From page 13<br>psychotropic regimen. | W 263 | | |
| W 264 | 483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE<br><br>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview, and record review, the facility failed to ensure the use of a door alarm was reviewed and or monitored for relevancy for three of five clients residing in the facility. [Clients #3, #4, and #5]<br><br>The finding includes:<br><br>As the Residential Director provided the survey team a walk-thru of the home on the morning of 11/3/2009 at approximately 10:00 a.m., door alarms were observed on the rear doors of Client #3 and #4's bedrooms. The RD opened the rear doors in these bedrooms and confirmed that the door alarms were active. Further interview with the RD revealed the door alarms were put in place due to Client #5's history of elopements. The RD also stated that it had been over a year since Client #5 has attempted to elope from the facility.<br><br>Review of the Human Rights Committee meeting notes on 11/3/2009 at approximately 3:10 p.m. | W 264 | W264<br><br>The alarm system was reviewed by the HRC and approved based on the elopement issue (See: attached copies)...12-20-09.<br>The issue will be revised 1-29-10. | |

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| I 224 | Continued From page 2<br>Mentally Retarded Person (GHMRP) failed to ensure training was provided to seven of thirteen staff in the area of Mental Retardation. (Staff #1, #3, #5, #7, #9, #11 and #12)<br><br>The finding includes:<br><br>Interview with the QMRP and review of the staff training records on 11/4/2009 at approximately 12:30 p.m. verified seven out of thirteen staff failed to receive training to cover an overview of mental retardation. | I 224 | All staff will receive oral hygiene training from the RN with emphasis put on supporting individuals with proper tooth brushing...12-30-09.<br>It should be noted that Client #1 presents specific issues around oral hygiene and dental care because she resists staff support and the dentist when she receives treatments. The dentist is successful in treating her despite the behavior and staff incurs similar issues when supporting her during tooth brushing. The QMRP will consult with the behavior specialist to determine if a protocol can be developed that will help staff be more successful in supporting Client #1 during tooth brushing. If it is determined that a protocol can help, the behavior specialist will develop it and train staff on the prescribed techniques...12-30-09. | |
| I 226 | 3510.5(c) STAFF TRAINING<br><br>Each training program shall include, but not be limited to, the following:<br><br>(c) Infection control for staff and residents;<br><br>This Statute is not met as evidenced by:<br>Based on record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure training was provided to nine of thirteen staff in the area of Infection Control. (#1, #3, #5, #7, #8, #9, #10, #11 and #12)<br><br>The finding includes:<br><br>Interview with the QMRP and review of the staff training records on 11/4/2009 at approximately 12:40 p.m. verified nine out of thirteen staff failed to receive training in the management of infection control. | I 226 | | |
| I 228 | 3510.5(e) STAFF TRAINING<br><br>Each training program shall include, but not be | I 228 | 3510.5(e)<br><br>See responses for 3510.5(a) above. | |

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| I 229 | Continued From page 4<br>training records on 11/4/2009 at approximately 1:00 p.m. verified six out of thirteen staff failed to receive training in behavior management. | I 229 | | |
| I 232 | 3510.5(i) STAFF TRAINING<br><br>Each training program shall include, but not be limited to, the following:<br><br>(i) Training of the residents in the maintenance of oral health and hygiene.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHMRP (Group Home for Mentally Retarded Persons) failed to ensure effective education and training in the maintenance of good dental hygiene for two of the three residents in the sample. (Residents #1 and #2)<br><br>The findings include:<br><br>1. The GHMRP failed to ensure training to staff and the residents as recommended to improve the residents' dental hygiene.<br><br>The facility failed to ensure training to staff and the Residents as recommended to improve the Residents' dental hygiene.<br><br>Interview with the staff on 11/2/09 at 3:37 p.m. revealed the Residents required assistance in all activities of daily living, including tooth brushing. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the Residents did not have formal training objectives to enhance their skills in toothbrushing. Further interview with the QMRP, however, revealed that staff had been instructed to assist the Resident's in brushing their teeth three times daily and to | I 232 | | |

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| I 232 | Continued From page 5<br>document the toothbrushing in the Residents' record.<br><br>Record review 11/4/09 at 4:00 p.m. verified that the QMRP had instructed the staff during a meeting on 1/9/09, to brush the Residents' teeth 3 times daily, however, all staff had not been present at the meeting. Subsequently, there was no evidence that each staff had been trained on dental hygiene.<br><br>Further interview with the primary R.N. on 11/3/09 at 12:15 p.m., revealed that the dental visits for Residents #1 and #2 were current.<br><br>2. The review of dental consultation reports for Resident #1 and #2 revealed poor oral hygiene had been identified during dental assessments as evidenced below:<br><br>a. On 11/4/09 at 9:39 a.m., Resident #1 dental consultation report dated 11/26/08 revealed a large amount of plaque and calculus, and that material alba was present on tooth surfaces. The Resident received a general scaling with prophylaxis and polishing on 1/27/09. Brushing two to three times daily was recommended. On 5/18/09, the Resident was again diagnosed with large deposits of plaque and calculus. She was recommended to return to the dental clinic for a full mouth scaling, which she received on July 28, 2009. There was no evidence, however, that the toothbrushing procedures implemented had been adequate to prevent the rapid accumulation of plaque and calculus on the Resident's teeth.<br><br>b. Record review on 11/4/09 at 12:12 p.m., revealed that Resident #2 had a dental consultation on 11/26/08. The finding was "large amount plaque, calculus, and material alba | I 232 | | |

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| I 232 | Continued From page 6<br><br>present on teeth surfaces. Poor oral hygiene." On 1/27/09, the Resident returned to the dentist for generalized scaling prophylaxis and polishing of teeth. Brushing two to three times daily was recommended. During a follow-up appointment on 5/18/09, the Resident was again diagnosed with moderate deposits of plaque and calculus. At the time of the survey, there was no evidence evidence that the facility had implemented an effective brushing program to improve the Resident's dental hygiene. | I 232 | | |
| I 375 | 3519.6 EMERGENCIES<br><br>Each GHMRP shall document each emergency and enter the follow-up actions into the resident ' s permanent record, which shall be made available for review by authorized individuals.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review the Group Home for the Mentally Retarded Person (GHMRP) failed to document the follow-up actions for an incident of a missed medication at the day program as required by this section for one of three residents in the sample. [Resident #3]<br><br>The findings include:<br><br>1. Record review on 11/3/2009 at approximately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Resident #3's habilitation record. The incident report was dated 2/11/2009 from Resident #3's day program and it provided information regarding an "omission of medications". A memorandum from the day program dated 3/6/2009 verified and substantiated the findings. This memo was attached to this incident report | I 375 | | |

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| I 375 | Continued From page 7<br>and it detailed the following:<br><br>"During an internal review/investigation of the medication protocol for [Day Program], a medication omission error was discovered by [Day Program] Incident Manager. On Wednesday, 2/11/2009, [Day Program} employed a temp nurse via [Staffing Agency] who failed to administer medications to [Resident #3] on this date. We apologize for the delay in notification; however, upon becoming aware of this omission we felt it imperative to inform you."<br><br>Further record review revealed on the same day at approximately 10:40 a.m. revealed, Resident #3 was prescribed to receive 10mg of Reglan (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders.<br><br>Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:09 p.m. revealed the information was substantiated, but there was no supporting evidence presented during the survey to substantiate the actions the GHMRP took to address the problem.<br><br>2. Record review on 11/3/2009 at approximately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Resident #3's habilitation record. The incident report was dated 2/11/2009 from Resident #3's day program and it provided information regarding an "omission of medications". A memorandum from the day program was attached to this incident report and it detailed the following: | I 375 | | |

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| I 375 | Continued From page 8<br>"On 2/11/2009, eighteen individuals at [Day Program] missed their 12noon dosage of prescribed medications/or treatments. The temporary registered nurse assigned by [Staffing Agency] to administer medication on this date failed to complete this responsibility."<br><br>Further record review revealed on the same day at approximately 10:40 a.m. revealed, Resident #3 was prescribed to receive 10mg of Reglan (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders.<br><br>Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:08 p.m. revealed she did not complete an investigation into this neglectful situation. As such, the QMRP also failed to provide the Department of Health with her investigative findings as well. | I 375 | 3519.6<br><br>This is a case of an incident occurring at the day program that was not detected or reported in a timely manner. Once the day program did uncover the issue, it disclosed to MTS and provided its investigation report. MTS could not report what it did not know about and perhaps incorrectly assumed that the day program would disclose the incident to the State Agency as well as provide its investigation report. In the future, MTS will insure that it forwards any incident reports and investigations it receives from day programs for incidents that occur at the day program to the State Agency the same day that it receives it... 12-20-09. It should be noted that no harm resulted in the missed medication passes and that this was a single occurrence caused by the circumstances that day at the program and not an ongoing concern or problem. Nevertheless, the QMRP will monitor this consideration during her routine, monthly visits to the program... 12-20-09. | |
| I 379 | 3519.10 EMERGENCIES<br><br>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.<br><br>This Statute Is not met as evidenced by:<br>Based on staff interview and record review the Group Home for the Mentally Retarded Person | I 379 | 3519.10<br><br>See the responses for W153. In addition, the QMRP did not seek to conduct an investigation at the day program based on the described incident. The day program conducted its own investigation and provided MTS with its report/findings. Residential staff cannot conduct investigations at non-affiliated, sister day programs unless given special permission to do so or the program agrees to a joint investigation. Neither was necessary in this case. The day program, once it uncovered the incident, investigated and provided its findings. As mentioned in W153, MTS will insure that it passes on such incident reports and investigations received from day programs the day they are received... 12-20-09. | |

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| I 379 | Continued From page 9<br>(GHMRP) failed to ensure an incident of a missed medication at the day program was reported to DOH as required for one of three residents in the sample. [Resident #3]<br><br>The finding includes:<br><br>Record review on 11/3/2009 at approximately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Resident #3's habilitation record. The incident report was dated 2/11/2009 from Resident #3's day program and it provided information regarding an "omission of medications". A memorandum from the day program was attached to this incident report and it detailed the following:<br><br>"On 2/11/2009, eighteen individuals at [Day Program] missed their 12noon dosage of prescribed medications/or treatments. The temporary registered nurse assigned by [Staffing Agency] to administer medication on this date failed to complete this responsibility."<br><br>Further record review revealed on the same day at approximately 10:40 a.m. revealed, Resident #3 was prescribed to receive 10mg of Reglan (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders.<br><br>Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:07 p.m. revealed she was notified of the missed medication on 3/9/2009. She was not sure why it took the day program almost a month to notify her of the incident. But, the QMRP failed to notify the Department of Health of this medication error as well. | I 379 | | |

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| I 379 | Continued From page 10<br><br>At the time of the survey, the GHMRP had not notified the Department of Health of this incident. | I 379 | | |
| I 401 | 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS<br><br>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.<br><br>This Statute is not met as evidenced by:<br>Based on observation interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure professional services were provided in accordance with the needs of two of the three residents in the sample. (Resident's #1 and #2)<br><br>The findings include:<br><br>A. The GHMRP failed to ensure preventive health services were coordinated for the completion of recommended diagnostic procedures for Residents #1 and #2 as evidence below:<br><br>1. The GHMRP failed to ensure that Resident #2 was received a hematology follow-up as prescribed.<br><br>On 11/2/09 at 8:02 a.m., Resident #2 was administered Ferrous Sulfate 325 (65 mg) tablet. Interview with the medication nurse during this time revealed the resident received the medication to prevent a low iron level. Record verification on 11/3/09 at 9:05 a.m. confirmed that the resident had a physician's order to receiver | I 401 | 3520.3<br><br>1. Client #2 received hematology follow up on...11-6-09<br>(Copy attached)<br>2. Client #1 had a Prolactin level done on 9-26-09 (copy attached)...9-26-09.<br>The level was high and the PCP will monitor the level but indicated that the current level is not an issue unless she begins lactating...12-14-09.<br><br>As indicated by the surveyor, a gap in completing quarterly nursing physicals was created by the departure of one RN and the time it took to replace her. Quarterly nursing physicals are current for each person supported at this time. In the future, the Director of Nursing will insure that no such gap occurs by assigning another RN to complete the task, using consultants in the absence of a permanent RN or by completing the task herself...12-30-09<br><br>Interviews with medication nurses indicate that the treatment was given but not properly documented (Hydrogen Peroxide to ears). The RN will train medication passing nursing to insure that they document all medications and treatments consistently...12-30-09. Additionally, the RN will audit the MARs at minimum weekly to insure the above...12-30-09 | |

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| I 401 | Continued From page 12<br>times. Continued record review however revealed no laboratory reports of prolactin level were available.<br><br>Interview with the primary R.N. on 11/4/09 at 9:30 a.m. evidence that no laboratory test to assess Prolactin values had been conducted.<br><br>B. The GHMRP failed to ensure that Residents #1 and #2 received a physical examination by a Registered Nurse at least quarterly as evidenced below:<br><br>Interview with the primary R.N. on 11/3/09 at 4:40 p.m. revealed that she began working at the group home on 8/13/09. Further interview with the R.N. revealed at that time she began a review of all of the resident's records to determine the status of assessments and appointments/consultations.<br><br>On 11/4/09 at 9:22 a.m., and 11:29 a.m. respectively, review of medical records of Residents #2 and #1 revealed that a six month period had elapsed between quarterly nursing assessments as follows:<br><br>a. Resident #2 had a 2nd quarterly assessment on 4/3/09, then the next nursing quarterly was conducted on 10/7/09, 5 months later.<br><br>b. Resident #1 had a 2nd quarterly assessment on 4/9/09, then next nursing quarterly assessment was conducted on 9/28/09, 5 months later.<br><br>The R.N. acknowledged that there had been a break between the time the previous primary R.N. was transferred from the GHMRP and the time that she began working at the GHMRP. There | I 401 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HFD03-0236 | A. BUILDING _____ B. WING _____ | 11/04/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MULTI-THERAPEUTIC SERVICES, INC | 927 55TH STREET, NE WASHINGTON, DC 20019 |

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| I 401 | Continued From page 13<br>was no evidence that the GHMRP had ensure that each resident received a physical assessment at least quarterly.<br><br>C. The GHMRP failed to ensure that medication was administered without error for Resident #2 as evidenced below:<br><br>Interview with the primary R.N. on 11/3/09 at 2:18 p.m. revealed that Resident #2's treatment prescribed to prevent ear wax impaction was changed by the primary care physician in July 2009.<br><br>Record review on 11/3/09 at 4:49 p.m. revealed a physician's order dated 7/21/09 for H2O2 + Mineral Oil 1/2/ + 1/2 in dropper bottle, 3 gtt to each ear 3 x a month - each ear. The review of the medication administration record, however, revealed no documentation that the peroxide (H2O2) + mineral oil drops had not been administered to the resident on any day in July 2009. There was no evidence the GHMRP ensured the resident's medication was administered without error. | I 401 | | |
| I 402 | 3520.4 PROFESSION SERVICES: GENERAL PROVISIONS<br><br>Professional services shall include an annual health inventory of each resident.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff interview and record review the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure that residents received an annual Speech and Language evaluation for one of three sampled Residents. [Resident #3] | I 402 | 3520.4<br><br>The QMRP will insure that the communication issue is addressed in the upcoming ISP meeting and thereafter and will thereafter insure via monthly monitoring and reviews that follow up occurs in a timely manner... 12-30-09. See also responses for W249. | |

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| I 402 | Continued From page 14<br>The finding includes:<br><br>On 11/2/2009 between the hours of 3:30 p.m. and 6:50 p.m., Resident #3 was observed sitting in front of a small table in the living room listening to music from a small portable radio. Resident #3 was escorted from this seat between 5:52 p.m. and 6:21 p.m. to have dinner. After dinner she was allowed to return to her chair to listen to more music. She remained there until 6:50 p.m. when the survey team left the GHMRP.<br><br>Record review on 11/3/3009 at approximately 11:05 a.m. revealed, Resident #3's Speech (SLP) assessment dated 7/7/2008 recommended the following:<br><br>1. Continue building [the] Resident's receptive and expressive language skills through recreational/social interactions as well as using 1 to 1 time allowing resident to express herself.<br><br>2. Re-assess communication skills annually to monitor significant changes and adjust programming as necessary.<br><br>Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at 2:50 p.m. revealed Resident #3 did not have a current communication program in place and an updated SLP assessment was still pending.<br><br>The GHMRP failed to ensure the timely implementation of Resident #3's communication program and re-assessment as recommended by the Speech and Language Pathologist (SLP). | I 402 | | |

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| I 401 | Continued From page 11<br>Ferrous Sulfate 325 (65 mg) tab TID on Monday trough Friday and BID on Saturday and Sundays for anemia.<br><br>Interview with the primary R.N. on 11/3/09 at 11:00 a.m. revealed that Resident #2 was being monitored by the hematologist. Record review revealed a hematology consultation report dated 6/23/08 on which it was noted that the resident had a diagnosis of microcytosis and should return to the hematology clinic in one year for follow-up. At the time of the survey, there was no evidence that the one year follow-up appointment had been completed for the resident.<br><br>2. The GHMRP failed to ensure the pharmacist's recommendation that Resident #1's Prolactin be monitored every six months was addressed as evidenced below:<br><br>On 11/2/09 at 8:30 a.m., Resident #1 was administered Haldol 5 mg tab (3 tabs, 15 mg). The resident lay on the floor and attempted to bang her head as the nurse verbally prompted her to get up from the floor. Interview with the medication nurse revealed the Haldol was prescribed to manage the resident's psychosis. Subsequent record review on 11/2/09 at 9:07 a.m. revealed a current physician's order, with an original date of 7/7/08 for Haloperidol 5 mg tab, 15 mg by mouth twice daily in the morning and evening for psychosis.<br><br>Record review on 11/4/09 at 9:17 A.M. revealed a 5/11/09 Quarterly Pharmacy Review which stated "Haldol - Needs Prolactin Q 6 months". The review of the resident's Quarterly Pharmacy Reviews dated 11/25/08, 2/25/09, and 8/6/09 revealed assessment of of the Resident 's prolactin level was also recommended at those | I 401 | | |